



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Kingwood Medical Center

**Respondent Name**

TASB Risk Mgmt. Fund

**MFDR Tracking Number**

M4-17-2859-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

May 30, 2017

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "...the hospital would have been entitled to \$4,247.84 in reimbursement. The Carrier only paid \$1,838.73. Therefore, the Hospital contends and additional \$2,409.11 remains owed."

**Amount in Dispute:** \$2,409.11

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "A reconsideration was received on 1/18/17 and processed timely. The carrier did not make any additional payments at that time."

**Response Submitted by:** TASB Risk Management Fund, 12007 Research Blvd., Austin Texas 78759-2439

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5-6, 2016	Outpatient Hospital services	\$2,409.11	\$2,409.11

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 97 – Payment is included in the allowance for another service/procedure
  - P12 – Workers' compensation jurisdictional fee schedule adjustment
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

- W3 – Additional payment made on appeal/reconsideration

### Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The requester seeks additional reimbursement for \$2,409.11 for outpatient hospital services rendered October 5 – 6, 2016.

The insurance carrier reduced the disputed services with reduction codes, P12 – “Workers compensation jurisdictional fee schedule adjustment,” and 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”

These outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS).

The resources that define the components used to calculate the Medicare payment for OPSS are:

- **How Payment Rates Are Set**, found at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf),
  - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPSS or under another payment system or fee schedule. The relevant status indicator may be found at the following: [www.cms.gov](http://www.cms.gov), Hospital Outpatient Prospective Payment – Final Rule, OPSS Addenda, Addendum, D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: [www.cms.gov](http://www.cms.gov), Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
- **Comprehensive** - Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

These payment policies are discussed below in the calculation of the maximum allowable reimbursement.

2. The Division rule pertaining to the calculation of fees for outpatient hospital services is found in 28 Texas Administrative Code §134.403 (f) which states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2017 Wage Index Adjustment for provider 0.9653	40% non-labor related	Payment
99285	8011	J2	\$2,174.14	$\$2,174.14 \times 60\% = \$1,304.48$	$\$1,304.48 \times 0.9653 = \$1,259.21$	$\$2,174.14 \times 40\% = \$869.06$	$\$1,259.21 + \$869.66 =$ $\$2,128.87 \times 200\% =$ $\$4,257.74$
						Total	\$4,257.74

The Medicare Claims Processing Manual found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> states in pertinent part;

#### 10.4 – Packaging,

##### C. Packaging Types Under the OPPS

6. J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. **Payment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met.**

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9. Comprehensive Observation Services C-APC (APC 8011) Effective January 1, 2016, CMS will provide payment for all qualifying extended assessment and management encounters through newly created C-APC 8011 (Comprehensive Observation Services). Any clinic visit, Type A Emergency Department (ED) visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital in conjunction with **observation services of eight or more hours, will qualify for comprehensive payment through C-APC 8011.** Effective January 1, 2016, CMS will no longer provide payment for extended assessment and management encounters through APC 8009 (Extended Assessment and Management Composite) and APC 8009 is deleted, effective January 1, 2016.

Also effective January 1, 2016, CMS has created new Status Indicator (SI) J2 to designate specific combinations of services that, when performed in combination with each other and reported on a hospital Medicare Part B outpatient claim, would allow for all other OPPS payable services and items reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services) to be deemed adjunctive services representing components of a comprehensive service and resulting in a

*single prospective payment through C-APC 8011 for the comprehensive service based on the costs of all reported services on the claim.*

Therefore, the single payment amount shown above is for the entire claim based on the applicable APC payment rate for APC 8011 as the number of reported observation hours (Code G0378) reported was 30 which satisfies the conditions of “packaging” as stated in the above Medicare payment policy.

The remaining services are classified as follows:

- Procedure code 36415, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
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- Procedure code 80053, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 82550, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 82553, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 84484, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 80053, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 82550, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 82553, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 83735, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 84100, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 84484, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 85027, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 85610, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 85730, billed October 5, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 85027, billed October 6, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code 70450, billed October 5, 2016, has status indicator Q3. As the criteria for packaging have been met for APC 8011, reimbursement is included in the APC payment for primary services.
- Procedure code 70450, billed October 6, 2016, has status indicator Q3. As the criteria for packaging have been met for APC 8011, reimbursement is included in the APC payment for primary services.
- Procedure code 99285, billed October 5, 2016, has a status indicator of J2. As shown above the APC payment is \$4,257.74.
- Procedure code 90714, billed October 5, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code 12001, billed October 5, 2016, has status indicator Q1. As the criteria for packaging have been met for APC 8011, reimbursement is included in the APC payment for primary services.

- Procedure code G0378, billed October 5, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

3. The total recommended reimbursement for the disputed services is \$4,257.74. The insurance carrier has paid \$1,838.73. The requestor is seeking additional reimbursement of \$2,409.11. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,409.11.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$2,409.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

### **Authorized Signature**

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

June 23, 2017

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**